

STATEMENT OF THE HONORABLE STEPHEN H. KAPLAN
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before the
COMMITTEE ON SCIENCE, SPACE, AND TECHNOLOGY
SUBCOMMITTEE ON TECHNOLOGY, ENVIRONMENT, AND
AVIATION
concerning
B757 WAKE TURBULENCE ISSUES
July 28, 1994

Mr. Chairman and Members of the Committee:

I am joined at the table by Linda Hall Daschle, Deputy Administrator of the Federal Aviation Administration. Secretary Peña and Administrator Hinson charged the two of us with reviewing the FAA's actions on the B757 wake vortex issue. We prepared the report dated July 26, 1994, that has been provided to the Subcommittee.

The Secretary and the Administrator directed the review with the overarching goal of assuring that FAA management of research and development, of safety data collection from the field, and the dissemination of information on emerging safety issues are all optimized to maintain the excellent U.S. aviation safety record the Congress and the traveling public have come to expect. As Administrator Hinson emphasized in his testimony, we are aware of the continued high level of commitment by your Subcommittee to the goal of aviation safety excellence.

A separate, important issue was the handling of an important Freedom of Information Act request filed by the Los Angeles Times on the B757 wake

vortex issue. The review found that the request was mishandled in several respects, and more than 700 documents have now been made available to the Los Angeles Times. Our recommendation in this area is to enhance the organizational responsibility and accountability for FOIA responses at the FAA in several important ways, including establishment of a FOIA Office within the Office of Public Affairs and improved staff training.

Ms. Daschle and I had the support of numerous, hardworking FAA and Departmental staff members in preparing the comprehensive document you have before you. In completing the report, the team reviewed over 700 documents and interviewed over 60 individuals. We approached this task with the goal of presenting a thorough, balanced and meaningful report, along with submitting recommendations based on the findings.

We believe this report should be considered in the context of the remarkable achievements of the FAA. The agency is rightly recognized throughout the world as the leader in aviation safety.

Our emphasis in the report is on the events that had a significant role in shaping the FAA's examination of wake vortex issues from 1987 through the present. A chronology of these events is set forth in Appendix A of the report. From your Subcommittee's perspective, the most important aspect of the chronology may be the management of research projects on wake turbulence generally and the B757 in particular.

Based upon our information, the review team could not conclude that any actions of the FAA would have prevented the Billings accident in

December 1992. As the NTSB has issued no probable cause findings in the December 1993 Santa Ana accident, we do not speculate on its cause.

The review team reflected a range of views on whether it would have been appropriate for the FAA to take additional steps regarding VFR operations prior to the Billings and Santa Ana accidents. One view is that it would have been appropriate for the FAA (1) to communicate directly with pilots to enhance their awareness of B757 wake vortex turbulence, (2) to encourage additional pilot training on visual landings behind a B757, and (3) to direct air traffic controllers to identify the B757 with a wake vortex turbulence warning to trailing aircraft.

The other view is that FAA took appropriate action in the circumstances given available information. During the time period reviewed and for many prior years, the FAA was active in educating pilots through extensive training and seminars about the well-known hazard of wake vortex in general, as well as in recent seminars where the subject of B757 wake vortex was specifically addressed. That the FAA did not pinpoint B757 wake vortex in some form of widely disseminated notification to pilots was justifiably attributable to the fact that prior to the Billings accident there was only one letter, from the Airline Pilots Association in 1988, that suggested the agency study the issue.

We conclude that the FAA's actions following the December 1993 Santa Ana accident were appropriate, effective, and indicative of a strong sense of commitment to safety.

We did not find that the FAA's wake vortex research program, whose primary objective was to increase capacity while maintaining safety, was handled appropriately. It appears that after the expenditure of over \$11 million in this area, little useful information was developed because of the program's low priority at the FAA, intermittent funding, high turnover in program managers, and changes in the program plan. Neither anecdotal data about the B757 prior to the agency's 1994 actions to increase separation, nor the more empirical data received from the U.K. Civil Aviation Authority, was treated as relevant to the decisionmaking process.

Although the FAA did not single out the B757 for special attention, our report confirms that the agency has long emphasized the hazards of wake vortices through a variety of educational activities, publications, and advisories, including the Airman's Information Manual. We also conclude that the FAA did not have data sufficient to increase IFR separation standards for the B757 prior to the agency's 1994 action to increase separation in response to the National Transportation Safety Board's recommendation.

Nonetheless, we do think the process to identify, track and address emerging safety issues at the FAA can be improved, as can the organizational structure related to safety issues generally. Deputy Administrator Daschle and I made a number of specific recommendations based on our findings, several of which I would like to restate here because of the Subcommittee's role in authorizing FAA research and development activities.

Our first recommendation is to improve the integration of research and development with operations to provide more effectiveness in resolving safety issues. This case makes clear that aviation research matters a lot.

The review team also recommends that the FAA continue to improve awareness and training among the pilot community about wake vortices. This training should take into consideration the concerns expressed by the NTSB regarding training of pilots to determine relative flight paths on approach to landing and wake vortex movement and avoidance techniques.

Another recommendation is that the FAA take a more pro-active approach to the dissemination of information on emerging safety issues. The FAA should evaluate its overall approach to dissemination of information to the aviation community regarding phenomena that fall short of an immediate demonstrable safety problem, but nonetheless give rise to sufficient concern that the agency believes that the community should have a heightened concern and awareness of the situation.

Another recommendation is to ensure that the study of a revised aircraft weight classification system continues to its conclusion and leads to a decision by a specified date.

The review team recommends that the Administrator study the role of the FAA's Office of Aviation Safety in light of the perceptions of the Office and the suggestions for improvement expressed in the

course of the review. In particular, the review team recommends that the Administrator consider a role for the Office or other mechanism that would address emerging safety issues by identifying and alerting the operational offices to such issues, track the status of those issues once they have been referred, and -- as priorities are set and budgets are developed in areas such as research and development -- point out how these decisions will affect progress toward safety goals.

An overall recommendation is to define management responsibility and accountability at the FAA more clearly. This applies to the research and development activities of the FAA as well as any others.

As we stated in our report, the B757 wake vortex episode should serve as a wake-up call to the FAA to re-examine its processes for addressing emerging safety issues promptly and effectively, for listening in a meaningful and sustained way to voices inside and outside the agency raising serious safety concerns, and for validating those concerns as a necessary predicate to safety decision-making. Maintaining the FAA's unparalleled safety record into the next century requires no less.

Mr. Chairman, this completes my prepared statement.